XI. Laboratory Services

Eff. 7-1-88 The State Agency will reimburse participating independent laboratories, outpatient surgical clinics, renal dialysis centers, and outpatient hospital clinics for covered laboratory services rendered on the basis of the allowable payment rates set by Medicare.

XII. (Deleted)

XIII. Family Planning Clinics

Eff. 7-1-87 The State Agency will reimburse participating family planning agencies for covered services in accordance with 42 CFR Section 447.321; payments shall not exceed applicable Title XVIII upper limits. Payments to physicians and Advanced Registered Nurse Practitioners (ARNP) for individual services shall not exceed the following amounts:

	Physicians	ARNP
Initial Clinic Visit	$50.00	$37.75
Annual Clinic Visit	$60.00	$45.00
Follow-up Visit with Pelvic Examination	$25.00	$18.75
Follow-up Visit without Pelvic Examination	$20.00	$15.00
Counseling Visit	$13.00	$13.00
Counseling Visit w/3 months contraceptive supply	$17.00	$17.00
Counseling Visit w/6 months contraceptive supply	$20.00	$20.00
Supply Only Visit - Actual acquisition cost of contraceptive supplies dispensed		

XIV. Durable Medical Equipment, Appliances, and Medical Supplies

1. Participating providers will be reimbursed on the basis of usual and customary actual billed charges not to exceed Medicare upper limits for the particular item. If the durable medical equipment, appliance or medical supplies are covered by Medicaid, but not covered by Medicare, Medicaid will set the applicable upper limit. Medicaid established upper limits shall be based on standards of reasonableness and designed not to exceed area prevailing charges.

2. Reimbursement will be made for the following, as appropriate: the reasonable, allowable cost of the item of durable equipment or appliance, or the monthly rental of the item; or the rental purchase payment; the cost of delivery of the item if free delivery is not available (must be the usual and customary charges paid by all patients for the delivery of similar items); reasonable repairs; and extensive maintenance if recommended by the manufacturer to be performed by an authorized technician. When the monthly rental or rental purchase system is used, total payment may not exceed the reasonable, allowable cost of the item if purchased.

3. Reimbursement will not be made for that portion of the cost covered by the Title XVIII program, if any; or for an item of equipment or appliance which has been refused coverage by the Title XVIII program; or for costs which would be payable under Title XVIII, Part B if the otherwise eligible individual had paid the required premiums; or for routine periodic servicing, such as cleaning and checking, of equipment and appliances.

4. Deductible and coinsurance payments made will be based on the allowable charges as determined by the Title XVIII program, and no payment will be made for any portion which has not been allowed by the Title XVIII program.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Other diagnostic, screening, preventive and rehabilitative services provided by licensed mental health centers and primary care centers shall be reimbursed in accordance with the provisions of 42 CFR 447.325.

A. Section 1. Participating in-state mental health center providers shall be reimbursed as follows:

(1)(a) Payment rates for the rate year beginning July 1, 1991 shall be based on the following principles.

1. Interim (not final) rates for the nine (9) departmental direct service cost centers shall be set based on the latest available cost and statistical data from the mental health centers. The interim rate shall not exceed the interim upper limit which is shown in A(1)(a)3.

2. Costs used in setting the interim rates shall be trended (increased for inflation) to the beginning of the rate year and indexed for inflation (increased by an inflation amount which represents an average inflation rate for the rate year) with the inflation factor used being the Health Care Financing Administration Home Health Agency Market Basket National Forecast.

3. Departmental direct service costs shall be arrayed (the "interim" array) and the interim rate upper limit set at 130 percent of the median cost per unit of service, appropriately increased for inflation as measured by the Health Care Financing Administration Home Health Agency Market Basket National Forecast, of all participating centers plus fifty-two (52) cents.

4. The base rate shall be the allowable, reasonable cost for each service unit or the reasonable cost upper limit, whichever is less. Facilities shall also have added to their base rate the incentive payment described in item

2. Costs used in setting the rates shall be trended to the beginning of the rate year and indexed for inflation to the end of the rate year.

3. Direct service costs shall be arrayed and the upper limit set at 130 percent of the median cost per unit of service of all participating centers.

4. The base rate shall be the allowable reasonable cost for each service unit or the upper limit, whichever is less.

5. Each facility shall have added to its rate, as a cost savings incentive payment, for each direct cost center an amount equal to fifteen (15) percent of the difference between the facility's actual reasonable allowable cost for the cost center and the upper limit.

6. A funding adjustment amount (derived by dividing $1.3 million by the number of outpatient units of service) shall be added to the interim rate (without regard to upper limits) to improve compensation of service providers and encourage provision of additional services.

7. The interim rate shall be adjusted to final prospectively determined rates based on the audited or desk reviewed annual cost reports for the period ending June 30, 1992 with the cost reports indexed for inflation, the upper limits previously determined remaining in effect, and the same funding adjustment allowed.

(c) Payment rates for rate years beginning on or after July 1, 1993 shall be based on the following principles.

1. For the rate years beginning July 1, 1993 and July 1, 1994, the final prospectively determined rates for the direct service cost centers shall be determined based on each mental health center's audited cost report for the period ending June 30, 1992. If the cost report is not audited at the time of rate setting, the rate shall be adjusted upon completion of the audit or desk review. For the rate year beginning on or after July 1, 1995, the final prospectively determined rates for the direct service cost centers shall be determined based on each mental health center's audited cost report for the prior year. If the cost report is not audited at the time of rate setting, the rate shall be adjusted upon completion of the audit or desk review. For all years costs shall be actual, reasonable, and allowable costs.

2. Costs used in setting the rates shall be trended to the beginning of the rate year and indexed for inflation.

3. Direct service costs shall be arrayed and the upper limit set at 130 percent of the median cost per unit of service of all participating centers.

4. The base rate shall be the allowable reasonable cost for each service unit or the upper limit, whichever is less.

5. Each facility shall have added to its rate, as a cost savings incentive payment, for each direct cost center an amount equal to fifteen (15) percent of the difference between the facility's actual reasonable allowable cost for the cost center and the upper limit.

6. A funding adjustment amount (derived by dividing $1.3 million by the total number of outpatient units of service) shall be added to the rate (without regard to upper limits) to improve compensation of providers and encourage provision of additional services.

(2) Allowable costs shall not exceed customary charges which are reasonable. Allowable costs shall not include the costs associated with political contributions, travel and related costs for trips outside the state (for purposes of conventions, meetings, assemblies, conferences, or any related activities), the costs of motor vehicles used by management personnel which exceed $20,000 total valuation annually (unless the excess cost is considered as compensation to the management personnel), and legal fees for unsuccessful lawsuits against the cabinet. However, costs (excluding transportation costs) for training or educational purposes outside the state are allowable costs. Payments may be based on units of service such as fifteen (15) minute or hourly increments, or at a daily rate, depending on the type of service.

1992 with the cost reports indexed for inflation (increased by an inflation amount which represents an average inflation rate for the rate year) using the Health Care Financing Administration Home Health Agency Market Basket National Forecast as the inflation factor, and with the upper limits previously determined remaining in effect, the same funding adjustment allowed, and the cost savings incentive payment allowed as appropriate.

(c) Payment rates for rate years beginning on or after July 1, 1993 shall be based on the following principles.

1. Final prospectively determined rates for the nine (9) departmental direct service cost centers shall be set based on each mental health center's audited annual cost report for the prior year; if an audited cost report is not available, the most recent unaudited annual cost report shall be the basis for the rate with the rate adjusted as necessary at the time of audit or desk review of the cost center used in setting the rate. Costs shall be actual, reasonable, and allowable costs.

2. Costs used in setting the rates shall be trended (increased for inflation) to the beginning of the rate year and indexed for inflation (increased by an inflation amount which represents an average inflation rate for the rate year) with the inflation factor used being the Health Care Financing Administration Home Health Agency Market Basket National Forecast.

3. Departmental direct service costs shall be arrayed and the cost center upper limit set at 130 percent of the median cost per unit of service, appropriately increased for inflation as measured by the Health Care Financing Administration Home Health Agency Market Basket National Forecast.

4. The base rate shall be the allowable reasonable cost for each service unit or the cost center upper limit, whichever is less.

5. Each facility shall have added to its base rate, as a cost savings incentive payment, for each departmental direct cost center an amount equal to fifteen (15) percent of the difference between the facility's actual reasonable allowable cost for the cost center and the cost center upper limit.

6. A funding adjustment amount (derived by dividing $1.3 million by the number of outpatient units of service) shall be added to the rate (without regard to cost center upper limits) to improve compensation of service to providers and encourage provision of additional services.

(2) Allowable costs shall not exceed customary charges which are reasonable. Allowable costs shall not include the costs associated with political contributions, travel and related costs for trips outside the state for purposes of conventions, meetings, assemblies, conferences, or any related activities, the costs of motor vehicles used by management personnel which exceed $15,000 total valuation annually (unless the excess cost is considered as compensation to the management personnel), and legal fees for unsuccessful lawsuits against the cabinet. However, costs (excluding transportation costs) for training or educational purposes outside the state are allowable costs. Payments may be based on units of service such as fifteen (15) minute or hourly increments, or at a daily rate, depending on the type of service.

(3) The reimbursable departmental cost centers are on-site psychiatrist, on-site individual, off-site psychiatrist, off-site individual, group, personal care, therapeutic rehabilitation, inpatient hospital psychiatrist, and inpatient hospital other.

Section 2. Payments shall be based on costs which are allowable and reasonable. Notwithstanding the rates for

each facility developed through the preceding methodology, no rate may be paid to any facility that exceeds the customary charge of the provider or the prevailing charges in the locality for comparable services under comparable circumstances. In addition, rates paid to public facilities cannot exceed actual costs pursuant to 45 CFR Part 74.

Section 3. Reimbursement of Out-of-State Providers. Reimbursement to participating out-of-state mental health center providers shall be the lower of charges, or the facility's rate as set by the state Medicaid Program in the other state, or the upper limit for that type of service in effect for Kentucky providers.

B. For primary care centers, payments shall be made on the basis of reasonable allowable costs; payments shall not exceed the usual and customary charges or the prevailing charges in the locality for comparable services under comparable circumstances or the upper limits. Effective January 1, 1989, all primary care centers were placed on a universal rate year for purposes of payments. The most recent audited cost report will be used as the basis for the interim rate, with cost in each service area trended to the universal rate year and indexed for inflation to the end of that year. Providers, except the incentive eligible group, are subject to retroactive cost settlement. A provider will be considered a newly participating provider until a fiscal year end cost report containing 12 full months of audited data is received and utilized to establish the interim rate. For newly participating providers, the initial interim payment rate may be established on the basis of projected costs and visits. The rate will be reviewed on the basis of actual experience after three months and periodically thereafter as deemed necessary to determine whether an adjustment is necessary. Providers which at the beginning of the universal rate year have medical and nursing cost in the lowest one-fourth (1/4) of the array will receive an incentive payment; the incentive payment will be twenty (20) percent of the average composite interim rate of the incentive eligible group; the incentive payment will be paid only on visits which are not in excess of 10,000. The entire interim payment would be considered prospective in nature for the incentive eligible group in that there would be not settlement after audit requiring a payback, unless charges are less than payments; however, to the extent cost may exceed the interim payment, an upward adjustment will be made to compensate for the additional cost; at the time of settlement, the agency would receive the greater of the interim payment, or actual cost up to the upper limits, not to exceed charges.

For drugs for specified immunizations provided free from the Health Department to primary care centers for immunizations for Medicaid recipients, the cost of the drugs are paid to the Health Department. The specified immunizations are: diphteria and tetanus toxiods and pertuisis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any type(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

Effective January 1, 1989, the cost for these immunizations will not be allowed as a part of the primary care center cost base so long as these drugs are available free from the Health Department.

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